John T. Carroll, MD

PATIENT REGISTRATION

PATIENT INFORMATION Date ________________ Date of Birth______________________ Age_____________

Last Name ____________________________________First Name__________________________ MI__________

Address____

City ____ State__________________ Zip___________________

Preferred contact phone # (__________) ____________________ Secondary # (_________) _____________________

Social Security Number________-________-_________ Marital Status: Single Married Divorced Widowed (circle)

Employer or School ____ Occupation______________________

Employer Address____

City ___________________________ State____________ Zip __________ Work Phone _____________________

Referred by:

Preferred Pharmacy ____________________________ Address ________________________ Phone ______________

ALLERGIES: ____

Spouse (Parent) Name ____ Date of Birth ___________________

Spouse (Parent) Employer _____________________________________ Work Phone _________________________

Spouse (Parent) Employer Address ____ ________________________

INSURANCE INFORMATION Insurance Company Name ____

ID# ________________________________ Group # ________________________ CoPay_____________________

Subscriber Name____

Supplemental Insurance

Insurance Co.________________________________ ID# _______________________ Group # _______________

HIPAA ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE By signing below, I acknowledge that I received or have been given the opportunity to receive a copy of John T. Carroll's *Notice of Privacy Practices.*

CONSENT FOR TREATMENT I agree to any examination, treatment, and procedures that may be performed during office visits, including emergency treatment considered necessary by the doctor or his providers.

CONSENT: ELECTRONIC MEDICAL RECORD I understand that John T. Carroll, MD participates in the **Cadence Connect** program and that my data will be stored in a shared community electronic medical record. My clinical data may be shared with Cadence Health, its affiliates, and other healthcare providers who are associated with my medical care.

____ _______________________________

Signature Date

____

Parent/Guardian (Please Print)

John T. Carroll, MD
503 Thornhill Drive Carol Stream, Illinois 60188
630-653-4200 fax: 630-653-4242

COMMUNICATION CHOICES

Patient____ Date of Birth _____________________

By completing and signing this form, I authorize John T. Carroll, MD and/or his staff to contact me at:

Preferred method of contact:

Indicate by circling:

Preferred Contact Phone # (_______)______________ - _______________________Home / Cell / Work

Second Choice (_______)______________ - _______________________Home / Cell / Work

By completing and signing this form, I authorize John T. Carroll, MD and/or his staff to leave information regarding my medical condition on my:

Home Voicemail (_______)______________ - _______________________

Cell Phone Voicemail (_______)______________ - _______________________

Other______________ (_______)______________ - _______________________

In the space below, if desired, please indicate any personal representative who is permitted to receive or know information concerning your healthcare. A personal representative as defined under the Health Insurance Portability Act of 1996 (HIPAA) is any family member, friend, or individual designated by the patient to whom the patient's health information may be disclosed.

1. ____ Relationship _________________________

   Phone #______________________________________

2. ____ Relationship _________________________

   Phone #______________________________________

Signed ____ Date ________________________________

Print Name ____ Relationship to Patient ____________________

John T. Carroll, MD 503 Thornhill Drive
Carol Stream, Illinois 60188

STATEMENT OF FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your care and treatment.

In order for us to successfully bill your insurance company, we need complete and up to date registration information and require a copy of your insurance card at **each** visit.

PAYMENT

- All co-payments must be paid at the time of service.
- Non-covered services must be paid in full at the time of service.
- For obstetric care, payment arrangements will be made according to your expected insurance coverage. All portions of your care not covered by your insurance plan are due prior to delivery.
- If you are uninsured, or cannot provide proof of insurance, payment will be due in full at the time of service.
- We accept Cash, Check, Visa, and Master Card.

INSURANCE COVERAGE

Health insurance coverage varies and all services may not be covered. You, the patient, must educate yourself about what is covered and what is your responsibility. Many insurance companies have specific laboratories that your lab work must be sent to, please notify us of this information.

- You are responsible for any **copayments, deductibles, and non-covered charges at the time of service.** Your plan may require you to have a written referral from your primary care physician. If you do not obtain a referral your visit may not be covered. It is your responsibility to know if a referral is required. Once your insurance has paid, you will be billed for any patient portion.
- If you are covered by Medicare, please be aware that Medicare does not cover all services and lab tests. You will be responsible for all non-covered charges and co-payments.
- If you are covered by Medicaid, you must bring in current proof of coverage to **every visit**. Co-payments are due at the time of service.

ADMINISTRATIVE FEES

- There is a $10.00 fee to complete Disability/FMLA forms. If additional forms are requested, a fee of $10.00 will incur each time a form is completed. Please allow 7 days for these forms to be completed.
- Release and copying of Medical Records will incur a charge in compliance with Illinois law and requires a completed HIPAA compliant signed request.
- Should you have an outstanding balance that is your responsibility and is greater than 60 days old, we may access simple interest on the unpaid balance at the rate of 1.5% per month (annual rate of 18%).
- Delinquent accounts may be placed with a collection agency.
- Return checks will incur a $30 service fee.

AUTHORIZATION TO RELEASE INFORMATION

I authorize John T. Carroll, MD to release any medical or incidental information necessary to secure payment of benefits for medical services provided.

ASSIGNMENT OF BENEFITS

I authorize the assignment of benefits payable to John T. Carroll, MD for medical and surgical services provided by him or his office or by a third party on my behalf. I understand I am financially responsible for any balance not covered.

MEDICARE/MEDICAID

I certify that the information I have provided for payment is correct. I authorize the release of all records requested. I request that payment of benefits be made to John T. Carroll, MD in my behalf.

I have read, understand, and agree to the financial policy of John T. Carroll, MD. We reserve the right to revise or amend this policy.

Patient Name (please print)____Date _________________________

Signed ____ Rev 8/14